MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Anoka Rehab and Living Center
3000 4th Avenue
Anoka, MN 55303
Anoka County

Report #: H5205033

Date: March 3, 2014

Date of Visit: October 22 & 23, 2013
Time of Visit: 11:00 a.m. – 4:15 p.m.
1:00 p.m. – 4:40 p.m.

By: Deborah Neuberger, R.N., Special Investigator

Type of Facility: ☒ Nursing Home ☐ HHA ☐ Home Care Provider/Assisted Living
☐ SLF ☐ ICF/IID ☐ Home Care
☐ Hospital ☐ Other: _____

☒ Facility Self Report ☐ Complaint

Allegation(s): **It is alleged** that neglect occurred when a resident was found with his/her head wedged in the gap between the mattress and the grab bar with his/her head pressing up against the grab bar. As a result s/he sustained swelling to his/her right eye and there was an open wound to his/her head.

An unannounced visit was made at this facility and an investigation was conducted under:

☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☑ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☐ Federal Regulations for EMTALA (42 CFR Part 489)
☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)

☑ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
☐ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
☐ State Licensing Rules for Home Care (MN Rules Chapter 4668)
☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☐ State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☑ Neglect ☐ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

Neglect occurred when facility staff members changed the resident's mattress without adjusting the placement of the grab bars, leaving a large gap between the mattress and the grab bar. The resident's head became entrapped in the gap resulting in swelling and an open wound to the right side of the resident's face and right eye.

The resident was admitted to the facility with diagnoses that included Alzheimer's disease. The resident's physician ordered a specialized mattress to protect the resident from skin breakdown. The resident used grab bars attached to his/her bed. There was no evidence of an assessment indicating the reason for the grab bars. Although the specialized mattress was not as wide as the previous mattress, it was placed on the bed without adjusting the width of the grab bars leaving a gap between the mattress and the grab bars. The resident was found in the early morning with his/her head entrapped between the grab bar and the mattress. The right side of the resident's face was observed to be swollen and blood was observed on the resident's face and the grab bar. When facility staff members investigated the incident, an 8 cm. (3.5 inch) gap was found to exist between the resident's mattress and the inside surface of the grab bars. The resident returned to his/her previous level of functioning after the incident.

Staff members verified the resident was found at about 4:20 a.m. with his/her head entrapped between the mattress and the grab bars. The resident's face was swollen and there was blood and a superficial open area to the outer right corner of his/her right eye. The resident appeared to be in pain. The resident's injury was treated with the application of ice and pain medication at the facility.

Although the facility had policies in place to assess the resident for the need and ability to safely use the grab bar, this was not completed. Additionally, although the facility had policies in place to assess the grab bars for adherence to FDA guidelines for safe use of the grab bars prior to use, this was not completed.

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ individual(s) and/or ☒ facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility had policies in place to assess residents for the ability to safely use grab bars and medical need of grab bars. The facility had policies in place to assess physical devices (grab bars) for adherence to FDA guidelines for the safe use of grab bars. However the facility failed to supervise and assure staff were following policies.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) – Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No If no, specify: _____
(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) – Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557). No state licensing orders were issued.

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect
"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated
"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

☒ Medical Records	☒ Care Guide
☒ Medication Administration Records	☐ Treatment Sheets
☒ Facility Incident Reports	☒ Physician Progress Notes
☐ ADL (Activities of Daily Living) Flow Sheets	☐ Laboratory and X-ray Reports
☒ Physician Orders	☐ Social Service Notes
☒ Nurses Notes	☐ Meal Intake Records
☐ Activities Reports	☐ Weight Records
☐ Therapy and/or Ancillary Services Records	☒ Assessments
☒ Skin Assessments	☒ Care Plan Records

Other pertinent medical records:

☐ Hospital Records ☐ Ambulance/Paramedics ☐ Medical Examiner Records ☐ Death Certificate

☐ Police Report

Additional facility records:

☒ Resident/Family Council Minutes ☐ Personnel Records/Background Check, etc.

☒ Staff Time Sheets, Schedules, etc. ☒ Facility In-service Records

☒ Facility Internal Investigation Reports ☒ Facility Policies and Procedures

☐ Call Light Audits ☐ Other, specify: _____

Number of additional resident(s) reviewed: 13

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): ○ Yes ○ No ◉ N/A Specify: This was a facility report.

If unable to contact complainant, attempts were made on:
Date/time: _____ Date/time: _____ Date/time: _____

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation: ○ Yes ◉ No ○ N/A Specify: Unable to participate.

Did you interview additional residents: ◉ Yes ○ No

Total number of resident interviews: 7

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 12

Physician interviewed: ○ Yes ◉ No

Nurse Practitioner interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: _____

Attempts to contact: Date/time: _____ Date/time: _____ Date/time: _____

If unable to contact was subpoena issued: ○ Yes , date subpoena was issued _____ ○ No

Were contacts made with any of the following:
☐ Emergency personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☐ Wound Care	☐ Medication Pass	☐ Meals
☐ Personal Care	☒ Dignity/Privacy Issues	☐ Restorative Care
☒ Nursing Services	☒ Safety Issues	☒ Facility Tour
☐ Infection Control	☐ Cleanliness	☐ Injury
☒ Use of Equipment	☐ Transfers	☐ Incontinence
☐ Call Light	☒ Other: Grab bar use with specialized mattresses.	

Was any involved equipment inspected: ◉ Yes ○ No ○ N/A

Was equipment being operated in safe manner: ○ Yes ◉ No ○ N/A

Were photographs taken: ○ Yes ◉ No Specify: _____

xc: Division of Compliance Monitoring - Licensing & Certification
Minnesota Board of Examiners for Nursing Home Administrators
Minnesota Board of Nursing
Anoka City Police Department
Anoka City Attorney
Anoka County Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245205	A. BUILDING _____ B. WING _____	C 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTER	3000 4TH AVENUE ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate complaint #H5205033. The following deficiencies are issued: F 278 SS=E 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 000 F 278	F000 It is the policy of Anoka Rehabilitation and Living Center to follow all federal, state, and local guidelines, laws, regulations, and statutes. This plan of correction is not to be construed as an admission of deficient practice by the facility administrator, employees, agents, or other individuals. The response to the alleged deficient practice cited in this statement of deficiencies does not constitute agreement with citations. The preparation, submission, and implementation of this plan of correction will serve as our credible allegation of compliance. F278 It is the policy of Anoka Rehabilitation & Living to ensure that the assessment accurately reflect the resident's status.	

RECEIVED
DEC 31 2013
OHFC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Asst. Admin. — (X6) DATE: 12/30/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245205	A. BUILDING _____ B. WING _____	C 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTER	3000 4TH AVENUE ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 1 Based on observation, interview and document review the facility failed to ensure an assessment of resident needs that accurately reflected the resident's current status for 13 of 14 residents reviewed utilizing grab bars, Resident (R)-1, R-2, R-4, R-5, R-6, R-7, R-8, R-9, R-10, R-11, R-12, R-13 and R-14, with the potential to effect the 69 of 107 facility residents utilizing grab bars. Medical record review revealed R-1 was admitted to the facility in 2013 with diagnoses that included Alzheimer's disease. R-1's physical device assessment dated 8/12/2013 was reviewed and revealed the resident utilized grab bars on the resident's bed. The assessment failed to include the medical symptoms for the resident's use of the grab bars, the diagnoses related to the medical symptom, alternative measures attempted to treat medical symptoms, summary of potential risks associated with use or an assessment of the resident's ability to use the grab bars safely. Medical record review revealed R-2 was admitted to the facility in 1993 with diagnoses that included Multiple Sclerosis. R-2's physical device assessment dated 6/10/2013 was reviewed and revealed the resident utilized grab bars on the resident's bed. The assessment failed to include the medical symptoms for the resident's use of the grab bars, the diagnoses related to the medical symptom, alternative measures attempted to treat medical symptoms, summary of potential risks associated with use or an assessment of the resident's ability to use the grab bars safely. Medical record review revealed R-4 was admitted to the facility in 2013 with diagnoses that included	F 278	For Residents identified in the 2567 dated 12/16/13 a new assessment was completed for physical devices by 11/18/13. Corresponding updates have been made to the care plan, care assignment sheets, and communicated to the resident and/or designated decision maker. The primary physician was informed of the assessment results and a review of the current physician orders was completed. Education has been provided for staff members regarding physical device data collection and evaluation by 11/30/13 and as needed. For other residents who may be affected by this practice, an audit on physical devices was completed by 11/30/13. Upon this review, system revisions and/or staff education was implemented by 11/30/13 and will continue as needed. RECEIVED DEC 31 2013 OHFC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245205	A. BUILDING _____ B. WING _____	C 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTER	3000 4TH AVENUE ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 2 falls and anemia. R-4's physical device assessment dated 7/2/2013 was reviewed and revealed the resident utilized grab bars on the resident's bed. The assessment failed to include the medical symptoms for the resident's use of the grab bars, the diagnoses related to the medical symptom, alternative measures attempted to treat medical symptoms, summary of potential risks associated with use or an assessment of the resident's ability to use the grab bars safely. Medical record review revealed R-5 was admitted to the facility in 2011 with diagnoses that included Congestive Heart Failure. R-5's physical device assessment dated 10/23/2012 was reviewed and revealed the resident utilized grab bars on the resident's bed. The assessment failed to include the medical symptoms for the resident's use of the grab bars, the diagnoses related to the medical symptom, alternative measures attempted to treat medical symptoms, summary of potential risks associated with use or an assessment of the resident's ability to use the grab bars safely. Medical record review revealed R-6 was admitted to the facility in 2013 with diagnoses that included Cellulitis and End Stage Renal Disease. R-6 was identified by facility staff as utilizing grab bars. R-6's physical device assessment for the use of the grab bars was requested, but no physical device assessment was provided. Medical record review revealed R-7 was admitted to the facility in 2013 with diagnoses that included Chronic Airway Obstruction. R-7's physical device assessment dated 9/27/2013 was reviewed and revealed the resident utilized grab	F 278	The policy for physical device data collection and evaluation has been reviewed and revised by the interdisciplinary team. A review of policies by the Medical Director was completed to ensure current standards of practice are in place. Staff members were trained as it relates to their respective roles and responsibilities regarding the physical device data collection and evaluation policy and procedures by 11/30/13. Physical device audits will be completed weekly for 4 weeks, monthly for 3 months, then as needed to ensure compliance with results reported to the QA/QI Committee for review and further recommendations. Further system revision and staff education will be provided if indicated by audits. The Director of Nursing or designee will be responsible for compliance. Date of Correction: 12/14/13 RECEIVED DEC 31 2013 OHFC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245205	A. BUILDING _____ B. WING _____	C 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTER	3000 4TH AVENUE ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 3 bars on the resident's bed. The assessment failed to include the medical symptoms for the resident's use of the grab bars, the diagnoses related to the medical symptom, alternative measures attempted to treat medical symptoms, summary of potential risks associated with use or an assessment of the resident's ability to use the grab bars safely. Medical record review revealed R-8 was admitted to the facility in 2013 with diagnoses that included Tibia fracture. R-8 was identified by facility staff as utilizing grab bars. R-8's physical device assessment for the use of the grab bars was requested, but no physical device assessment was provided. Medical record review revealed R-9 was admitted to the facility in 2013 with diagnoses that included arthritis. R-8 was identified by facility staff as utilizing grab bars. R-9's physical device assessment for the use of the grab bars was requested, but no physical device assessment was provided. Medical record review revealed R-10 was admitted to the facility in 2012 with diagnoses that included Atrial Fibrillation. R-10 was identified by facility staff as utilizing grab bars. R-10's physical device assessment for the use of the grab bars was requested, but no physical device assessment was provided. Medical record review revealed R-11 was admitted to the facility in 2013 with diagnoses that included Chronic Kidney Disease. R-11 was identified by facility staff as utilizing grab bars. R-11's physical device assessment for the use of the grab bars was requested, but no physical	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245205	A. BUILDING _____ B. WING _____	C 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTER	3000 4TH AVENUE ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 4 device assessment was provided. Medical record review revealed R-12 was admitted to the facility in 2013 with diagnoses that included Hypertension. R-12 was identified by facility staff as utilizing grab bars. R-12's physical device assessment for the use of the grab bars was requested, but no physical device assessment was provided. Medical record review revealed R-13 was admitted to the facility in 2013 with diagnoses that included dementia. R-13 was identified by facility staff as utilizing grab bars. R-13's physical device assessment for the use of the grab bars was requested, but no physical device assessment was provided. Medical record review revealed R-14 was admitted to the facility in 2012 with diagnoses that included Chronic Airway Obstruction. R-14's physical device assessment dated 7/12/2013 was reviewed and revealed the resident utilized grab bars on the resident's bed. The assessment failed to include the medical symptoms for the resident's use of the grab bars, the diagnoses related to the medical symptom, alternative measures attempted to treat medical symptoms, summary of potential risks associated with use or an assessment of the resident's ability to use the grab bars safely. A facility tour was conducted on 10/22/2013 at 12:50 p.m. and grab bars were observed on the beds of R-2, R-3, R-4, R-5, R-6, R-7, R-12, R-13 and R-14. Administrative Registered Nurse (RN)-C was interviewed on 10/22/2013 at 12:00 p.m. and	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245205	A. BUILDING _____ B. WING _____	C 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTER	3000 4TH AVENUE ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 5 provided a list of 69 residents currently utilizing grab bars on their beds. RN-C confirmed that although 69 residents were utilizing grab bars, not every resident using grab bars on his/her beds had an accurate assessment related to the use of the device. The policy titled Physical Device Data Collection and Evaluation dated Revised January 2010 and provided by the facility was reviewed. Under the section titled Procedure the following was noted: 1. With the collaboration of the interdisciplinary team, a physical device data collection will be performed/collected on admission, annually and the initiation of to ensure the safety of the resident utilizing the physical device. 2. Our devices will follow the FDA guidelines and will be assessed prior to use and at a minimum quarterly for appropriate dimensions. 3. All physical devices will have a medical symptom to warrant use... 7. Check all of the specific medical symptoms which require use of a physical device. 8. Check and/or place a in comment box the appropriate disease process or diagnosis correlated with the medical symptom. 9. Check what type of therapeutic intervention is intended for the use of the device. 10. Describe alternative measures used, trial or considered for use of least restrictive device. 11. Describe outcomes of alternatives trialed.	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245205	A. BUILDING _____ B. WING _____	C 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTER	3000 4TH AVENUE ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 6 12. Summarize the plan and associated risk factors for use of the physical device.	F 278		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure that the resident environment remains as free of accident hazards as is possible for 3 of 15 residents reviewed, Residents (R)-1, (who experienced head entrapment between the mattress and a grab bar), R-2, and R-3 who had large spaces (5 or more inches) between the mattress and grab bars, with the potential for entrapment. Findings include: Medical record review revealed R-1 was admitted to the facility 5/10/2013 with diagnoses that included Alzheimer's disease. R-1's Quarterly review for the use of devices dated 8/12/2013 was reviewed and revealed R-1 utilized left and right grab bars on his/her bed. R-1's careplan dated 5/20/2013 was reviewed and revealed that R-1 required the extensive assist of 2 for transfers, and was at risk for falls related to cognitive impairment and agitation.	F 323	F323 It is the policy of Anoka Rehabilitation & Living Center that each resident receives adequate supervision and assistance to prevent accidents. For Residents identified in 2567 dated 12/16/13 a new assessment for physical devices was completed by 11/30/13. Corresponding updates have been made to the care plan, care assignment sheet and communicated to the resident and/or designated decision maker. The primary physician was informed of the assessment results and a review of the current physician orders was completed by11/30/13. All staff members responsible were educated on physical device policies and procedures by 11/30/13.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245205	A. BUILDING _____ B. WING _____	C 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTER	3000 4TH AVENUE ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7 R-1's nursing note dated 10/12/2013 and signed by Licensed Practical Nurse (LPN)-D was reviewed and revealed LPN-D entered R-1's room at 4:20 a.m. and saw R-1 holding the left grab bar with both hands with his/her face below his/her hands. R-1's face was facing down with his/her head wedged between the grab bar and the mattress, with his/her right temple pressed against the grab bar. When the resident was moved s/he was noted to have a reddened and swollen right eye with a superficial open area measuring 0.3 cm by 1 cm on the outer corner of the right eye. R-1's on-call physician was notified and ice was applied to reduce the swelling. The resident was non verbal but appeared to be in pain and was treated with pain medication. LPN-D was interviewed on 10/24/2013 at 8:30 a.m. and stated s/he entered R-1's room at about 4:20 a.m. S/he saw R-1 with his/her hand on the left grab bar face down. There was a gap between the mattress and the grab bar and R-1's head was in the gap. R-1's temple was resting against the grab bar. When staff turned R-1 the resident's right eye was red, swollen and R-1 had a superficial open area to the outer corner of his/her right eye. R-1 had last been seen about 1 hour before and at that time was resting comfortably in bed. LPN-D stated the mattress on the bed was a new mattress, placed on the bed that night for the purpose of skin protection/healing. Registered Nurse (RN)-C, Administrative Nurse, was interviewed on 10/22/2013 at 12:00 p.m. and stated s/he was informed of the incident immediately. RN-C stated that s/he investigated the incident and found an 8 cm gap between the	F 323	For other residents who may be affected by this practice a comprehensive record review of physical devices will be completed by 11/30/13. After review updates will be made as appropriate for each resident identified. The policy and procedure for physical devices was reviewed and revised by the interdisciplinary team by 11/30/13. A review of policies by the Medical Director will be completed to ensure current standards of practice are in place. Staff members were trained as it relates to their respective roles and responsibilities regarding the physical device policy and procedures by 11/30/13. Physical device audits will be completed weekly for 4 weeks, monthly for 3 months, and then as needed to ensure continued compliance. The results will be reported to the QA/QI Committee for review and further recommendation. The Director of Nursing or designee will be responsible for compliance. Date of Correction: 12/14/13.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245205	A. BUILDING _____ B. WING _____	C 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTER	3000 4TH AVENUE ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 8 mattress and the grab bar on R-1's bed. RN-C stated the new mattress, called an APM-2 mattress was narrower that the original mattress. RN-C stated that the original mattress was wide and utilized extenders on the beds to accommodate the width. When the extenders were removed from R-1's bed on 10/12/2013 after the incident, the APM-2 mattress fit snugly between the grab bars. Medical record review revealed R-2 was admitted to the facility in 1993 with diagnoses that included multiple sclerosis. R-2's device assessment dated 6/10/2013 was reviewed and revealed R-2 used left and right grab bars on his/her bed. R-2's careplan dated 6/27/2013 was reviewed and revealed R-2 was at risk for falls related to seizures and required the maintenance of a safe environment. Medical record review revealed R-3 was admitted to the facility in 2013 with diagnoses that included hypertension, CVA (stroke) and diabetes. R-3's device assessment dated 6/27/2013 was reviewed and revealed R-3 utilized left and right grab bars on his/her bed. R-3's careplan dated 6/28/2013 was reviewed and revealed R-1 required the extensive assistance of 1 staff member for transfers and ambulation. A facility tour was conducted on 10/22/2013 at 12:50 p.m. A gap was observed on R-2's bed between the mattress and the inside surface of the grab bar. The gap was measured at 5 inches. Extenders were observed to be on R-2's bed. A gap was observed on R-3's bed between the mattress and the inside surface of the grab bar. The gap was measured to be 5 1/2 inches. Extenders were observed to be on R-3's bed.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245205	A. BUILDING _____ B. WING _____	C 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTER	3000 4TH AVENUE ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 9 Facility staff immediately removed the extenders on the beds of R-2 and R-3. R-2 and R-3's beds were observed again on 10/22/2013 at 1:22 p.m. and the mattresses were observed to have no gap between the mattress and the inside surface of the grab bar. The policy titled Physical Device Data Collection and Evaluation dated revised January 2010 was reviewed and revealed the following under Procedure: 2. Our devices will follow the FDA guidelines and will be assessed prior to use and at a minimum quarterly for appropriate dimensions. The document titled Guidance for Industry and FDA Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment issued March 10, 2006 was reviewed and revealed the "FDA is recommending a dimensional limit of less than 120 mm (4 3/4 inches) for the area between the inside surface of the rail and the compressed mattress."	F 323		

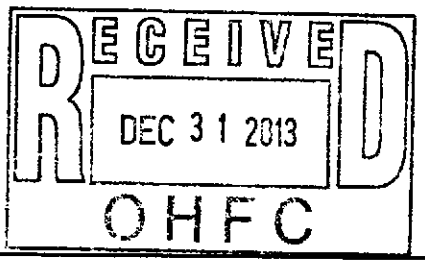
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00893	A. BUILDING: _____ B. WING _____	C 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTEI	3000 4TH AVENUE ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5205033. The following correction order issued.	2 000	RECEIVED DEC 31 2013 OHFC Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00893	A. BUILDING: _____ B. WING _____	C 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTEI	3000 4TH AVENUE ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in	2 830		

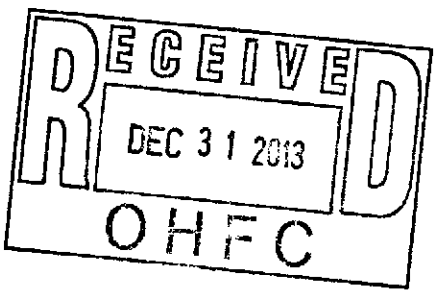
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00893	A. BUILDING: _____ B. WING _____	C 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTEI	3000 4TH AVENUE ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 2 the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide nursing care based on an accurate assessment of resident needs for 13 of 14 residents reviewed utilizing grab bars, Resident (R)-1, R-2, R-4, R-5, R-6, R-7, R-8, R-9, R-10, R-11, R-12, R-13 and R-14, with the potential to effect the 69 of 107 facility residents utilizing grab bars. Findings include: Based on observation, interview and document review the facility failed to ensure an assessment of resident needs that accurately reflected the resident's current status for 13 of 14 residents reviewed utilizing grab bars, Resident (R)-1, R-2, R-4, R-5, R-6, R-7, R-8, R-9, R-10, R-11, R-12, R-13 and R-14, with the potential to effect the 69 of 107 facility residents utilizing grab bars. Medical record review revealed R-1 was admitted to the facility in 2013 with diagnoses that included Alzheimer's disease. R-1's physical device assessment dated 8/12/2013 was reviewed and revealed the resident utilized grab bars on the resident's bed. The assessment failed to include the medical symptoms for the resident's use of the grab bars, the diagnoses related to the medical symptom, alternative measures	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00893	A. BUILDING: _____ B. WING _____	C 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTEI	3000 4TH AVENUE ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 3 attempted to treat medical symptoms, summary of potential risks associated with use or an assessment of the resident's ability to use the grab bars safely. Medical record review revealed R-2 was admitted to the facility in 1993 with diagnoses that included Multiple Sclerosis. R-2's physical device assessment dated 6/10/2013 was reviewed and revealed the resident utilized grab bars on the resident's bed. The assessment failed to include the medical symptoms for the resident's use of the grab bars, the diagnoses related to the medical symptom, alternative measures attempted to treat medical symptoms, summary of potential risks associated with use or an assessment of the resident's ability to use the grab bars safely. Medical record review revealed R-4 was admitted to the facility in 2013 with diagnoses that included falls and anemia. R-4's physical device assessment dated 7/2/2013 was reviewed and revealed the resident utilized grab bars on the resident's bed. The assessment failed to include the medical symptoms for the resident's use of the grab bars, the diagnoses related to the medical symptom, alternative measures attempted to treat medical symptoms, summary of potential risks associated with use or an assessment of the resident's ability to use the grab bars safely. Medical record review revealed R-5 was admitted to the facility in 2011 with diagnoses that included Congestive Heart Failure. R-5's physical device assessment dated 10/23/2012 was reviewed and revealed the resident utilized grab bars on the resident's bed. The assessment failed to include the medical symptoms for the resident's use of	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00893	A. BUILDING: _____ B. WING _____	C 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTEI	3000 4TH AVENUE ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 4 the grab bars, the diagnoses related to the medical symptom, alternative measures attempted to treat medical symptoms, summary of potential risks associated with use or an assessment of the resident's ability to use the grab bars safely. Medical record review revealed R-6 was admitted to the facility in 2013 with diagnoses that included Cellulitis and End Stage Renal Disease. R-6 was identified by facility staff as utilizing grab bars. R-6's physical device assessment for the use of the grab bars was requested, but no physical device assessment was provided. Medical record review revealed R-7 was admitted to the facility in 2013 with diagnoses that included Chronic Airway Obstruction. R-7's physical device assessment dated 9/27/2013 was reviewed and revealed the resident utilized grab bars on the resident's bed. The assessment failed to include the medical symptoms for the resident's use of the grab bars, the diagnoses related to the medical symptom, alternative measures attempted to treat medical symptoms, summary of potential risks associated with use or an assessment of the resident's ability to use the grab bars safely. Medical record review revealed R-8 was admitted to the facility in 2013 with diagnoses that included Tibia fracture. R-8 was identified by facility staff as utilizing grab bars. R-8's physical device assessment for the use of the grab bars was requested, but no physical device assessment was provided. Medical record review revealed R-9 was admitted to the facility in 2013 with diagnoses that included arthritis. R-8 was identified by facility staff as	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00893	A. BUILDING: _____ B. WING _____	C 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTEI	3000 4TH AVENUE ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 5 utilizing grab bars. R-9's physical device assessment for the use of the grab bars was requested, but no physical device assessment was provided. Medical record review revealed R-10 was admitted to the facility in 2012 with diagnoses that included Atrial Fibrillation. R-10 was identified by facility staff as utilizing grab bars. R-10's physical device assessment for the use of the grab bars was requested, but no physical device assessment was provided. Medical record review revealed R-11 was admitted to the facility in 2013 with diagnoses that included Chronic Kidney Disease. R-11 was identified by facility staff as utilizing grab bars. R-11's physical device assessment for the use of the grab bars was requested, but no physical device assessment was provided. Medical record review revealed R-12 was admitted to the facility in 2013 with diagnoses that included Hypertension. R-12 was identified by facility staff as utilizing grab bars. R-12's physical device assessment for the use of the grab bars was requested, but no physical device assessment was provided. Medical record review revealed R-13 was admitted to the facility in 2013 with diagnoses that included dementia. R-13 was identified by facility staff as utilizing grab bars. R-13's physical device assessment for the use of the grab bars was requested, but no physical device assessment was provided. Medical record review revealed R-14 was admitted to the facility in 2012 with diagnoses that included Chronic Airway Obstruction. R-14's	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00893	A. BUILDING: _____ B. WING _____	C 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTEI	3000 4TH AVENUE ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 6 physical device assessment dated 7/12/2013 was reviewed and revealed the resident utilized grab bars on the resident's bed. The assessment failed to include the medical symptoms for the resident's use of the grab bars, the diagnoses related to the medical symptom, alternative measures attempted to treat medical symptoms, summary of potential risks associated with use or an assessment of the resident's ability to use the grab bars safely. A facility tour was conducted on 10/22/2013 at 12:50 p.m. and grab bars were observed on the beds of R-2, R-3, R-4, R-5, R-6, R-7, R-12, R-13 and R-14. Administrative Registered Nurse (RN)-C was interviewed on 10/22/2013 at 12:00 p.m. and provided a list of 69 residents currently utilizing grab bars on their beds. RN-C confirmed that although 69 residents were utilizing grab bars, not every resident using grab bars on his/her beds had an accurate assessment related to the use of the device. The policy titled Physical Device Data Collection and Evaluation dated Revised January 2010 and provided by the facility was reviewed. Under the section titled Procedure the following was noted: 1. With the collaboration of the interdisciplinary team, a physical device data collection will be performed/collected on admission, annually and the initiation of to ensure the safety of the resident utilizing the physical device. 2. Our devices will follow the FDA guidelines and will be assessed prior to use and at a minimum quarterly for appropriate dimensions.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00893	A. BUILDING: _____ B. WING _____	C 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTEI	3000 4TH AVENUE ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 7 3. All physical devices will have a medical symptom to warrant use... 7. Check all of the specific medical symptoms which require use of a physical device. 8. Check and/or place a in comment box the appropriate disease process or diagnosis correlated with the medical symptom. 9. Check what type of therapeutic intervention is intended for the use of the device. 10. Describe alternative measures used, trial or considered for use of least restrictive device. 11. Describe outcomes of alternatives trialed. 12. Summarize the plan and associated risk factors for use of the physical device. SUGGESTED METHOD OF CORRECTION: The administrator or designee could update facility policies and procedures related to accurate assessment of residents utilizing physical devices, train staff on the new policies and monitor implementation of the policies. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible.	21665		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00893	A. BUILDING: _____ B. WING _____	C 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTEI	3000 4TH AVENUE ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21665	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure that the resident environment remains safe for 3 of 15 residents reviewed, Residents (R)-1, (who experienced head entrapment between the mattress and a grab bar), R-2, and R-3 who had large spaces (5 or more inches) between the mattress and grab bars, with the potential for entrapment. Findings include: Medical record review revealed R-1 was admitted to the facility 5/10/2013 with diagnoses that included Alzheimer's disease. R-1's Quarterly review for the use of devices dated 8/12/2013 was reviewed and revealed R-1 utilized left and right grab bars on his/her bed. R-1's careplan dated 5/20/2013 was reviewed and revealed that R-1 required the extensive assist of 2 for transfers, and was at risk for falls related to cognitive impairment and agitation. Medical record review revealed R-2 was admitted to the facility in 1993 with diagnoses that included multiple sclerosis. R-2's device assessment dated 6/10/2013 was reviewed and revealed R-2 used left and right grab bars on his/her bed. R-2's careplan dated 6/27/2013 was reviewed and revealed R-2 was at risk for falls related to seizures and required the maintenance of a safe environment. Medical record review revealed R-3 was admitted to the facility in 2013 with diagnoses that included hypertension, CVA (stroke) and diabetes. R-3's device assessment dated 6/27/2013 was reviewed and revealed R-3 utilized left and right grab bars on his/her bed. R-3's careplan dated 6/28/2013 was reviewed and revealed R-1	21665		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00893	A. BUILDING: _____ B. WING _____	C 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTEI	3000 4TH AVENUE ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21665	Continued From page 9 required the extensive assistance of 1 staff member for transfers and ambulation. R-1's nursing note dated 10/12/2013 and signed by Licensed Practical Nurse (LPN)-D was reviewed and revealed LPN-D entered R-1's room at 4:20 a.m. and saw R-1 holding the left grab bar with both hands with his/her face below his/her hands. R-1's face was facing down with his/her head wedged between the grab bar and the mattress, with his/her right temple pressed against the grab bar. When the resident was moved s/he was noted to have a reddened and swollen right eye with a superficial open area measuring 0.3 cm by 1 cm on the outer corner of the right eye. R-1's on-call physician was notified and ice was applied to reduce the swelling. The resident was non verbal but appeared to be in pain and was treated with pain medication. LPN-D was interviewed on 10/24/2013 at 8:30 a.m. and stated s/he entered R-1's room at about 4:20 a.m. S/he saw R-1 with his/her hand on the left grab bar face down. There was a gap between the mattress and the grab bar and R-1's head was in the gap. R-1's temple was resting against the grab bar. When staff turned R-1 the resident's right eye was red, swollen and R-1 had a superficial open area to the outer corner of his/her right eye. R-1 had last been seen about 1 hour before and at that time was resting comfortably in bed. LPN-D stated the mattress on the bed was a new mattress, placed on the bed that night for the purpose of skin protection/healing. Registered Nurse (RN)-C, Administrative Nurse, was interviewed on 10/22/2013 at 12:00 p.m. and stated s/he was informed of R-1 becoming entrapped between the grab bar and the mattress	21665		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00893	A. BUILDING: _____ B. WING _____	C 11/04/2013

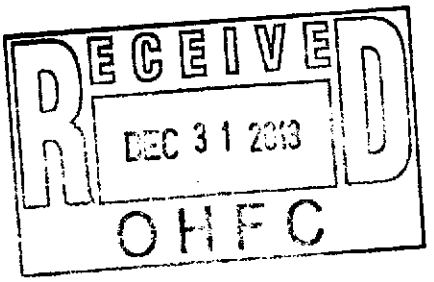
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTEI	3000 4TH AVENUE ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21665	Continued From page 10 immediately. RN-C stated that s/he investigated the incident and found an 8 cm gap between the mattress and the grab bar on R-1's bed. RN-C stated the new mattress, called an APM-2 mattress was narrower that the original mattress. RN-C stated that the original mattress was wide and utilized extenders on the beds to accommodate the width. When the extenders were removed from R-1's bed on 10/12/2013 after the incident, the APM-2 mattress fit snugly between the grab bars. A facility tour was conducted on 10/22/2013 at 12:50 p.m. A gap was observed on R-2's bed between the mattress and the inside surface of the grab bar. The gap was measured at 5 inches. Extenders were observed to be on R-2's bed. A gap was observed on R-3's bed between the mattress and the inside surface of the grab bar. The gap was measured to be 5 1/2 inches. Extenders were observed to be on R-3's bed. Facility staff immediately removed the extenders on the beds of R-2 and R-3. R-2 and R-3's beds were observed again on 10/22/2013 at 1:22 p.m. and the mattresses were observed to have no gap between the mattress and the inside surface of the grab bar. The policy titled Physical Device Data Collection and Evaluation dated revised January 2010 was reviewed and revealed the following under Procedure: 2. Our devices will follow the FDA guidelines and will be assessed prior to use and at a minimum quarterly for appropriate dimensions. The document titled Guidance for Industry and FDA Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment	21665		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00893	A. BUILDING: _____ B. WING _____	C 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTEI	3000 4TH AVENUE ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21665	Continued From page 11 issued March 10, 2006 was reviewed and revealed the "FDA is recommending a dimensional limit of less than 120 mm (4 3/4 inches) for the area between the inside surface of the rail and the compressed mattress." SUGGESTED METHOD OF CORRECTION: The administrator or designee could update facility policies and procedures related to monitoring the dimensions of the area between the mattress and inside surface of the grab bars on the beds of residents utilizing grab bars, train staff on the new policies and monitor implementation of the policies. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21665		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Post Correction Order Follow-Up/Federal Certification Review Report
PUBLIC DATA

Facility:
Anoka Rehabilitation and Living Center
3000 4th Avenue
Anoka, MN 55303
Anoka County

Report #: H5205033

Date: January 14, 2014

Date of Visit: January 10, 2014
Time of Visit: 9:00 a.m. - 5:00 p.m.

By: Diane Wallner, R.N.
Special Investigator

Nature of Visit
An unannounced visit was made in order to follow-up two federal deficiencies and two state licensing orders which were issued on December 16, 2013, as the result of an investigation which had been completed on November 4, 2013.

The status of each order is as follow:
1 MN Rule 4658.0520 Subp. 1 - Corrected
2 MN Rule 4658.1400 - Corrected

See Attached 2567B for status of federal deficiencies.

xc: Minnesota Department of Health -Licensing & Certification Division

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245205	A. Building B. Wing	1/10/2014

Name of Facility	Street Address, City, State, Zip Code
ANOKA REHABILITATION AND LIVING CENTER	3000 4TH AVENUE ANOKA, MN 55303

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0278 Reg. # 483.20(g) - (j) LSC	Correction Completed 01/10/2014	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 01/10/2014	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/4/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00893	A. Building B. Wing	1/10/2014

Name of Facility	Street Address, City, State, Zip Code
ANOKA REHABILITATION AND LIVING CENTER	3000 4TH AVENUE ANOKA, MN 55303

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. LSC	01/10/2014	ID Prefix 21665 Reg. # MN Rule 4658.1400 LSC	01/10/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/4/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO